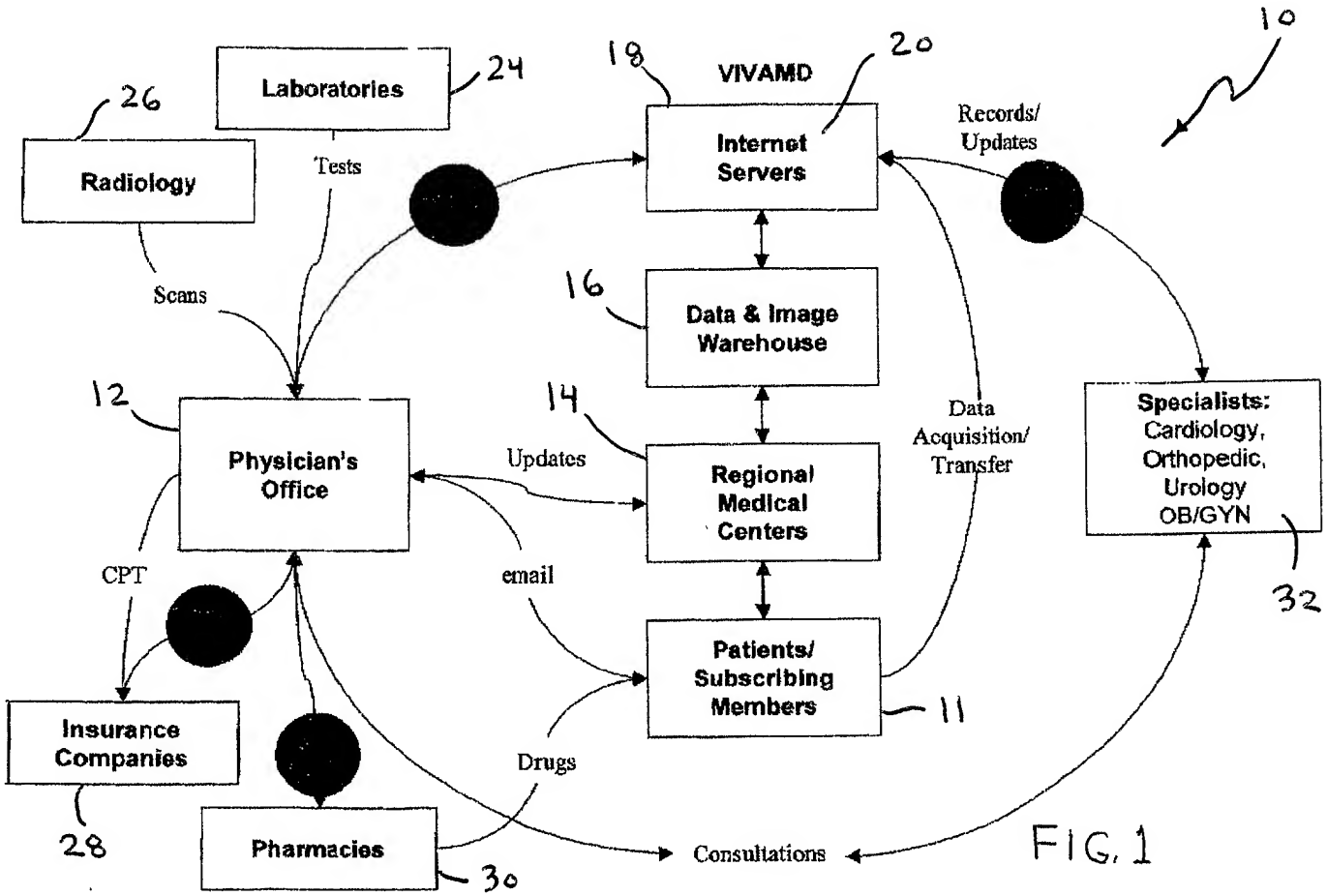
10
Laboratories
24
18
VIVAMD
20
26
Radiology
Tests
Internet Servers
Records/ Updates
Scans
16
Data & Image Warehouse
12
14
Physician's Office
Updates
Regional Medical Centers
Data Acquisition/ Transfer
Specialists: Cardiology, Orthopedic, Urology OB/GYN
32
CPT
email
Patients/ Subscribing Members
11
Insurance Companies
Drugs
28
Pharmacies
30
Consultations

FIG. 1

ACTIVITY REPORT

DATE	PHYSICIAN	ENCOUNTER SUMMARY	MEDICAL RECORDS
02-08-2000	Moulton Family Practice	Click Here	Click Here
02-03-2000	Moulton Family Practice	Click Here	Click Here
10-14-1999	Moulton Family Practice	Click Here	Click Here
09-24-1999	Moulton Family Practice	Click Here	Click Here
05-21-1999	Moulton Family Practice	Click Here	Click Here
05-18-1999	Moulton Family Practice	Click Here	Click Here
02-25-1999	Moulton Family Practice	Click Here	Click Here
11-18-1998	Moulton Family Practice	Click Here	Click Here
10-21-1998	Dr.Fong	Click Here	Click Here
08-21-1998	Moulton Family Practice	Click Here	Click Here
07-24-1998	Moulton Family Practice	Click Here	Click Here
07-15-1998	Dr.Fong	Click Here	Click Here
06-10-1998	Dr.Fong	Click Here	Click Here
05-29-1998	Moulton Family Practice	Click Here	Click Here
05-19-1998	Moulton Family Practice	Click Here	Click Here
04-17-1998	Moulton Family Practice	Click Here	Click Here
02-27-1998	Moulton Family Practice	Click Here	Click Here
01-16-1998	Moulton Family Practice	Click Here	Click Here
10-31-1997	Moulton Family Practice	Click Here	Click Here
09-05-1997	Moulton Family Practice	Click Here	Click Here

FIG. 2

Medical Records

Encounter Summary

Date	Physicians	Chief Complaint	Diagnosis	Treatment	SEARCH ACTIVATION
11/27/99	Dr. Smith	1. Left Elbow Recheck	N/A	1. Left elbow x-ray. 2. Activity as Tolerated.	
11/13/99	Dr. Smith	Left Arm /Elbow Recheck.	Left Radial Head Fracture.	1. Posterior Splint. 2. F/U in 2 weeks & Re-xray. 3. Lab results discussed.	
11/12/99	Bristol Park Walk-In Clinic	1. Left Elbow Pain. 2. Numbness to Left Arm.	Left Elbow Injury, Possible Radial Head Fracture	1. Lab work: CBC, Chemistry, and UA. 2. EKG. 3. Posterior Splint to Left Arm. 4. F/U with PMD & take x-rays.	
2/19/99	Unidentifiable	Completion of Sports Form.	N/A	N/A	
11/28/98	Bristol Park Walk-In Clinic	1. Right Foot Pain	Strain Right Foot	1. Ice, elevation, and rest. 2. Elastic Bandage for support. Warm-Up & Stretch before and after Running/ Exercise.	

FIG. 3

Medical Records

Category / Files Summary

Month / Categories	Search 0-12	Single Event 13-24	Scan All 25-36	37-48
SOAPS	11/27/99 11/13/99 11/12/99 2/19/99	11/28/98 10/2/98 9/29/98 4/24/98 3/14/98 2/6/98 2/3/98	12/9/97 10/11/97 9/20/97 9/17/97 8/31/97 8/28/97 4/27/97 4/15/97 4/14/97 3/21/97 3/2/97 2/14/97 2/1/97 1/31/97	
Labs	11/12/99	2/27/98 2/6/98		
Radiology	11/27/99 11/12/99	11/28/98 10/2/98 4/24/98 2/3/98	10/11/97 9/20/97 8/28/97 4/15/97 1/31/97	
Pathology	N/A	N/A	N/A	N/A
Current Meds.	11/13/99	9/29/98	12/9/97	
Med. RX Status		9/29/98	12/9/97 3/21/97	
Med. Controls	?	?	?	
Previous Meds.	2/19/99	9/29/98		
Ongoing DX	11/13/99 11/12/99	9/29/98 3/14/98 2/6/98	12/9/97	
Resolved TX	11/27/99 2/19/99	9/29/98	4/27/97 4/15/97	
Preventive Therapies	11/13/99 11/12/99	11/2898 9/29/98	12/9/97	
Past Significant TX	11/27/99	10/2/98 2/3/98	12/9/97 8/28/97 1/31/97	
Current Specialist Care	N/A	N/A	N/A	N/A
Specialty Consultations			2/24/97 2/1/97	
Referral Tracking	11/12/99		2/14/97 2/1/97 1/31/97	

FIG. 4

Entering A Medical Record

These guidelines should be used when entering information from a medical record into the VIVA MD Category Files page setup. When looking through a medical record, the nurse needs to keep the different categories in mind. Some of the information may need to be duplicated, in order to be placed in separate files.

The category name and a description of the information to be placed in each file are given below.

1. SOAP	This category is for the physician's notes from an actual visit. The SOAP refers to S-Subjective, O-Objective information; A-The Physician's Assessment of the patient, and the physician's diagnosis; and the P-Plan of treatment. The physician, however, may not always use this exact documentation format, so it is critical that the nurse be able to recognize this information on any document. The information will be entered in with the date and then scanned into this file.
2. Labs	Actual laboratory reports will be entered in and scanned into this file. Information of lab results, whether it is on the SOAP or a laboratory report needs to be scanned into this file. This will include any and all laboratory findings, i.e. Urine dips or blood Glucose checks done, with a fingerstick method, done in the physician's office.
3. Radiology	Actual Radiology reports will be entered in and scanned into this file. Again, any information regarding radiology reports, whether on an actual radiology report or a SOAP report, for example, will need to be scanned into this file. This should include, but not limited to, Ultrasounds, Mammographys and MRIs.
4. Pathology	As with the two previous categories, actual pathology reports will need to be entered and scanned into this file.
5. Current Meds	This category includes all the medication that a patient is currently taking. This information can be obtained, from the physicians note, if there is not an actual copy of the prescription. However this information is obtained, it is to be entered and scanned into this file.
6. Med RX Status	This category includes the refill status of all current medications. The information may be obtained from the SOAP and again, not limited to, and entered and scanned into this file.

FIG. 5A

7. Med Controls	This category is date oriented, according to the medication that a patient is on, i.e., anti-inflammatory medicine, will need to have lab work done periodically, to check for toxic levels of the drug in the liver.
8. Previous Meds	This information may be obtained from the physician's SOAP. It will then need to be entered and scanned, into this file.
9. Ongoing DX	This file needs to contain any information dealing with the same complaint and diagnosis, according to the SOAP, from the date of the initial complaint. The information will need to entered and scanned into this file.
10. Resolved DX	The information for this file will coincide with the date on a SOAP, which has no further date links regarding this particular diagnosis.
11. Preventative Therapy	Any information found in the medical records dealing with a specific occurrence or visit to a health practitioner, that indicates Preventative measures, to lessen the complaints or prevent further problems, will need to be entered and scanned into this file.
12. Past Significant TX	Information regarding treatments that were beneficial to the patient and there outcome should be entered and scanned in this Field.
13. Current Specialist Care	This file needs to include the reports from specialists, i.e. neuro-logist, cardiologist, etc., that a patient might have seen other than Their primary care physician, and is currently seeing. These reports are to be entered and scanned into this file.
14. Specialty Consultations	This file deals with the correspondence of the primary care physician and the specialists and all materials should be entered in with the date and scanned.
15. Referral Tracking	The information in this file should coincide with a SOAP, from the primary care physician, that the patient was referred to a specialist. This information should be entered and scanned.
16. Misc. Studies And Tests	This file is for information regarding a test and or study, found in a patient's medical record, that will not fit into the named categories.
17. Patient Education Tracking	This information deals with any mention of teaching patient and or the patient's family or material given out to help promote awareness of any condition. This information must be entered in

FIG. 5B

and scanned into this file.

18. Immunizations	This involves the dates that a vaccination or immunization was given.
19. Misc. Entries	This file is for any documentation that can not be placed into the other categories or files.

With every category there may have a specific written entry or there may be information on a SOAP entry or elsewhere in the medical record. In any case, the information needs to be entered according to the page setup and scanned into the specific file.

When entering a medical record, there may not be information to be put into every category.

The same report or information may need to be scanned multiple times, so that it may be able to be placed into several different files and or categories.

FIG. 5C